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ABSTRACT

The paper traces the evolution of psychiatric care for children from an intrapsychic orientation to a new conceptual perspective provided by systems theory and the accompanying relational formulation of conflict. The interdisciplinary process prevents a challenge to professionals' collaboration and respect for other fields and mandates critical self-monitoring. Chaos results from a clash in interdisciplinary evaluation between the traditional linear behavioral perspective and a higher order circular and more relational point of view. Findings of an internal causal approach to a depressed 13-year old are contrasted with a family systems approach which highlighted the need for family psychotherapy to establish clear generational boundaries, help resolve old grief and anger issues and enhance the self-worth of individual members. (CL)

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THE USE OF EXTEMPORANEOUS ETHICS IN THE FORMULATION OF INTERDISCIPLINARY TEAM IMPRESSIONS AND RECOMMENDATIONS FOR HANDICAPPED CHILDREN

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INTRODUCTION

The word ethics denotes a practical discipline concerned with the norms of human conduct as well as with propositions about the process and results of such conduct. These basic propositions of ethics go so far as to describe to us what we should do, and do not simply describe how we do conduct ourselves or what goals we pursue and how we pursue them. Related issues continue to emerge, such as the relationship between knowing what is right and doing it, and discovering to what degree ethical problems themselves can be solved (Adler, 1977).

A pivotal issue in any discussion of an ethics dilemma is the one of ethical obligation. Further, any such discussion of moral obligation or duty itself cannot avoid a consideration of right and wrong. The ethical dilemma with which we concern ourselves as a central theme of this meeting, that of the ethical issues raised in the interdisciplinary team decision-making process can be frustrating at best. The point to which I have addressed my energy is merely to a review of the implications such ethical dilemmas may hold as a result of the use of extemporaneous ethics (i.e., any action or recommendation is acceptable if one believes it to be appropriate) in a diagnostic team situation, and to a consideration of the possible consequences for the patient, specifically the developmentally delayed child, and not to any solution of the ethical dilemma itself.

In this time of evolving ideas on how best to approach the

issue of the developmentally delayed child's emotional problems, much is being written on just what elements demand consideration in the interdisciplinary evaluation team process. We have become increasingly aware of the impact of the family and other interactional systems on the child's emotional condition and ultimate development, and mental health professionals have begun to assume a systems orientation when viewing the problems of such children.

The clinician assessing a delayed child must be able to observe the family as well as the child, and look at each of its members from a perspective respecting and understanding the fluid nature of the family system, since causes become effects and effects causes in the cyclical patterns of family interaction (Parker and Cooper, 1982).

Weber and Parker (1981) in a comparative study of family and professional views of the factors affecting positive family adjustment to a delayed child have said, "parents of such children should be referred to and included in the available supportive relationships and resources (i.e., family psychotherapy) which serve the child".

Heretofore, most traditional and many modern theorists have viewed the disturbed developmentally delayed child himself as the unit of analysis, and implied by this a linear view of causality for the child's problems which attempted to fix blame on persons, intrapsychic elements, events, or environmental circumstances within the child's realm of impact (Andolfi, 1979).

This view is no longer a useful one, as the need for whole system dynamics to be scrutinized becomes widely acknowledged.

Developmentally delayed children's emotional problems tell us that their developmental needs to become differentiated and autonomous have been renounced in support of the family's rigid relational system. Once symptom behaviors are defined as having such a function in the context in which they occur, traditional psychiatric diagnoses (e.g., "behavior disorder of childhood") lose their meaning (Andolfi, 1979).

THE ETHICAL DILEMMA

In the last twenty years, the emerging trend in treating psychiatric problems of children has involved a moving away from an intrapsychic frame of reference in formulation and treatment to the new conceptual perspective provided by systems theory and the accompanying relational formulation of conflict (Barragan, 1976). However, the body of theory based on this perspective and the concepts generated by it have contributed further to the ethical dilemma encountered by mental health professionals who recognize and acknowledge such concepts, but who continue to find themselves working with an interdisciplinary treatment team or in an assessment situation with other professionals who view a child's emotional problems internally.

One must raise not only the issue of the possible ethical conflict generated by differences of opinion on a diagnostic team, i.e., the process dilemma, but also the issue of where we as professionals may look for support for our position when we are in

fact, the "lone wolf" with our professional notions. Further political implications may arise when traditional "medical model" philosophy openly interferes with the true interdisciplinary process, requiring democratic and egalitarian recognition of one another among assessing team members (Davey, 1981; Pearson, 1982).

THE INTERDISCIPLINARY PROCESS

While the interdisciplinary process, as we have come to know it, may enhance the likelihood that the final impressions and recommendations concerning a child's condition will represent a gestalt of professional ideas -- a "whole greater than sum of parts" perspective -- it also increases the need for agreement and collaboration, and hence the opportunities for disagreement and dissension. In a multidisciplinary situation, such a dilemma would not be likely to present itself, as there would be little or no interaction among the experts assessing the developmentally delayed child's condition. Interpretation of the individual findings would then be done by each professional, or by one person who would gather notes from the others and assume a management role for the case (Pearson, 1982). Pearson continues in his description of the interdisciplinary team process in "The Interdisciplinary Team Process or the Professionals' Tower of Babel" by citing the need to find avenues for minimizing the possibilities for difference by "finding ways to forge workable linkages with our professional colleagues." This can be accomplished only if colleagues are aware and appreciative of the value of one

another's unique perspectives and information. The complement to such insight is then further insight about our own professional contributions, and expecially the imperative for them to be current, accurate, clear, and appropriate. Particularly for the purposes of this discussion of ethical dilemma, the necessity for accuracy and currency emerges as vital if we are to avoid the confused results of extemporaneous ethics. It is of particular frustration when dissension in such a situation as the interdisciplinary decision-making process is the result of insistence by one or more colleagues for outdated theory to be used in the weaving of the interdisciplinary formulation.

Davey (1981) in a review of the literature regarding multi- and interdisciplinary teams, says the single element most consistently identified as characteristic of the team approach to evaluation and treatment of the delayed child is "collaboration". Viewed even in the broadest sense, such collaboration implies not only mutuality of cooperation and assistance, but even more important, a mandate for critical self-monitoring, which would tend to preclude much of the dissonance generated when professional team members are contributing out-of-date, irrelevant, incomplete, and theoretically inappropriate information to the formulation of impressions and plan.

Mental health evaluation and treatment of developmentally disabled children are facilitated and enhanced by a systemic family approach. The ethical dilemma referred to here is generated by the conflict between outdated non-holistic linear

perspectives in evaluation and assessment and the more theoretically accurate higher order systemic diagnostic results, "as they are more effective and successful in moving to systems thinking" (Bowen, 1974, p. 122). The thesis is made then that the consequence of applying extemporaneous ethics, particularly within the process of interdisciplinary formulation, is often chaos. The effects of such process dilemmas are encountered often in diagnostic formulation within the treatment team process, and tend to force the very ethical issues generated by such conflicts.

THE THEORETICAL COMPARISON

Interest in family systemic theory continues to produce evidence to contribute to the belief that the processes which give rise to structural problems in the family system are also generating serious emotional problems in developmentally delayed children, and in turn, a reciprocal adaptive pattern of symptoms in such children. The family may continue to be overlooked in the evaluation and treatment processes as an agent both for support and change for the child's problems. Even when they are acknowledged, family members may be isolated from the treatment situation itself. In this case, the family system dysfunction is reinforced, as the therapist joins the family in focusing on the child as the generating agent of the problem (Barragan, 1976).

The major goal of interdisciplinary team assessment and diagnosis of the developmentally delayed child is that of

alteration of a state of "dis-ease" for which the child's parents have sought service and intervention. Psychiatric symptoms, however, tend to assume their meanings from the context in which they are viewed. Thus, if the emotional difficulties of these children are seen as behavioral disturbances, generated by, and a function of, internal conflict within individual children, then professionals are led inevitably to review only the condition of the patient himself, and to believe that the problem must lie primarily "within" him (Andolfi, 1979). Treatment in such situations then could conceivably consist of hospitalization, drug administration and other "individual" treatment techniques thought to be relevant to the patient's problem.

If, however, these identical symptoms were viewed as significant to a larger system difficulty, influencing, and in turn reciprocally influenced, supported and maintained by other system elements, one could then seek to find the relational/reciprocal meaning of the disturbing child-behavior, as well as its significance for the child's family (i.e., the symptom function). In such a context, treatment could then be conceived of as aiding this identified child patient and his family members to initiate functional changes in a system context which will also be changed and stimulated to use its own power to be therapeutic (Bowen, 1974; Andolfi, 1979).

On the other hand, therapy focusing on the delayed child, and the subsequent assignment of the responsibility for treatment

to a professional "expert", make assumptions that this identified patient is "ill". Such a linear model for causality has been widely accepted by the majority of mental health professionals as well as by the public utilizing their services in multidisciplinary settings. The developing roles between professionals and patients tend to become complementary, with the patients and their families providing data about the difficulty, and the professionals then providing complementary data about intervention (Andolfi, 1979).

CASE REVIEW

This case review compares and contrasts the impressions and recommendations formulated in mental health assessments of the same patient by two members of a child's interdisciplinary diagnostic team, albeit from different disciplines, but with one evolving out of the traditional linear behavioral perspective, and the other from a higher order circular and more relational point of view.

Concerns identified when the B. family applied for services for their 13-year-old son, Bill, were the boy's inability to make friends with young people his own age, his unhappiness, impulsiveness and irresponsibility, his intense distaste for school, his low self-image, and constant fighting with his 10-year-old brother. His mother reported his difficulties with school had begun the year he began kindergarten, and said many disturbing behaviors had followed and intensified during the years since that kindergarten year. She reported that her

subsequent divorce, a number of geographic moves, and a remarriage had all exacerbated her son's difficult adjustment problems.

Mrs. B., in the intake interview, reported that a major problem affecting the entire family was generated by the departure of the boy's natural father to VietNam when the child was 2 years old. She said his father was gone for a year, and the boy did not remember him when he returned and attempted to take charge of his son's life and remove him from the beloved grandparents with whom he had lived during that year. (The mother identified this traumatic experience as the boy's "personal VietNam" and reported he still carried "wounds" from that.)

Subsequent marital conflicts and the ensuing divorce causing the second separation of Bill from his father were "upsetting" to him. His mother stated that the reason for her divorce was the discovery that her husband was bi-sexual, and she said her son did not really understand why they were divorced. She was, she said, almost sure the child blamed himself for the divorce because he and his father had never gotten along very well. She reported, in fact, the boy had once told her he thought the reason they decided to have a second child was because he himself never "measured up" as a son. She said the boy's father had a way of making Bill feel inadequate no matter what he did, and she was concerned that it gave him a poor self-image, even before he had any school problems.

There were further reports in the intake data base of such

symptoms as nail biting, poor concentration, short attention span and distractibility, inability to get along with other children, low frustration level, and the preferring of younger children and adults to children his own age. She said Bill was easily frustrated and angered, unhappy, and felt himself to be "dumb". He was also said to be exhibiting jealousy with his brother and other children, and feeling that he could not "do very many things", especially his school work. Bill was reported to never stick with anything and to have few, if any, hobbies or interests. His mother said he seemed immature in some ways and overly sensitive and perceptive in others.

A psychological evaluation (performed at age 7) identified Bill as a child with basically normal intelligence, and while it mentioned that he appeared to have very little self-esteem at times and at other times appeared to have a very inflated assessment of his own abilities, it was believed by the tester that this fluctuation betrayed insecurity. At any rate, the only recommendation given was that the child be placed in a class for children with learning disabilities, predicting failure by his teachers unless a phonic method of teaching would be used. In addition, Mrs. B. was advised to become familiar with the principles of behavior modification to work with the boy's troublesome behaviors.

A questionnaire filled out and returned by the private school this young man was attending reported behavior to be his number one problem, and his social adjustment with peers to be

not grade-appropriate. He was said to be very defensive, arguing with and threatening his classmates, and primarily socializing with younger children. His strengths were identified as a desire to read, politeness, brightness and pursuit of knowledge about his major interests such as history. His weaknesses were said to be disorganization, poor expression (both verbal and written), very poor sentence and paragraph structure, and difficulty following instructions. An interesting and significant observation by one of Bill's teachers was that the boy expected his mother (also a teacher at his school) to handle his school-related problems for him. A low frustration tolerance, blaming external causes for behavior, and such anti-social tendencies as lying were listed as further concerns by teachers.

With data base collected, the interdisciplinary evaluation process began and this child was first seen for a full educational evaluation in order to establish baseline data on his levels of school skills development, and to rule out learning disabilities. Conclusions following this evaluation were that learning disabilities could in fact be ruled out for him as he could produce school behaviors that could be measured on the ninth to tenth grade level. Bill's case could then fall within the broader definition of developmental delay, that of a condition generally interfering with normal development.

During the family therapy assessment interview, a generalized air of depression was noticeable among family members as they sat, with Mrs. B. flanked by her sons, and the stepfather

seated apart from the group.

I asked Bill to discuss his family in a way that would help me get to know them a little better. He described a congenial relationship with his stepfather, and said his real father was in Texas. He reported his stepfather to be too busy to do things with him, and said he goes to his mother if he needs someone to talk to. During this report, Bill's mother (referred to by him as "Mommy") fondled and stroked her younger son, John, and glanced at him affectionately on numerous occasions, while Bill and his mother held hands.

Bill went on to describe his problems in school with boys his own age who tease him and refuse to accept him. He described himself as a "maverick, staying away from the herd". When he is rejected by the others, he said, "I leave; it's their turf. My turf is in the trees. When someone invades that, I'm angry."

Bill's brother, John, described himself and his mother as the two closest people in the family (Mrs. B. interrupted to say she had nursed John until he was five years old), and he and Bill as the two most distant. He said Bill is the "family problem", at which point Bill said, "I'm not the problem, my problem is the problem." John went on to describe his annoyance with Bill's pestering and picking fights, and attributed this quite honestly to his own teasing and tattling which he said have the effect of getting his mother to intervene in his behalf. John's image as the family "good compliant son" emerged quickly, as did Bill's as the family scapegoat and symptom bearer.

Bill continued to elaborate on his history of school and peer problems, saying he thought his troubles started when he began school, but his mother continually interrupted to insist they started when his father returned from the war. "That's when all our problems began." Mrs. B. began to cry at this point, saying, "The pain will never go away," reiterating her belief that those years were at the root of Bill's problem. Bill, at this point, said he didn't have a problem until John was born. "John took my mother away."

I shifted the focus to Mr. B. who described his feelings of fragmentation and helplessness with attempting to divide his time between wife, children, and graduate studies, and told how Bill was taking the brunt of his frustration because of the boy's disturbing behavior.

I asked Mr. B. if he ever felt as if there were a ghost living in his house. (It was apparent that Mrs. B.'s unresolved first marriage issues were not only still being borne by her, but were being assigned to Bill as well.) Mr. B. said he tried not to ask questions that would cause tears, and he described his perception of the changes in Mrs. B.'s personality since the disintegration of her marriage. (He had made assumptions about this from information contributed by her and her parents about the "old" Mrs. B.)

The depressed tone in this family group was remarkable. John alone seemed not to be weighed down by sadness. Bill's role as the bearer of family pain and anger, related to the

disintegration of his parents' marriage but still supported and maintained in the new family unit, presented a significant treatment issue for this family system.

The enmeshment evident in the relationships between Mrs. B. and both her sons was providing interference with individuation for all three, of particular developmental significance for John and Bill. Additional interference with the marital coalition was furnished by these overinvolved relationships.

Bill's self-concept was quite poor, and he was more than a little uncertain about his self-worth and his capacity to cope with his own problems. He did, in fact, express concern about these issues as he asked questions at his staffing conference. In reply to the question, "Bill, are there things you want to find out today?", he said, "Yes, I want to know if I'm fit to be on the earth."

The medical evaluation employed a developmental pediatric format, looking at current complaints and their history, in addition to the routine physical examination. The evaluator employed a "psychiatric" frame of reference to generate impressions and recommendations within the physical developmental overview. The diagnosis generated by this evaluation was "behavior disorder of childhood and now adolescence, characterized by very poor self-image", and the single recommendation was for "individual counseling and intervention to modify present behaviors contributing to this boy's inability to make friends and get along with peers."

It is interesting to note that within the "history of present complaints", this evaluation report stated the boy admitted other children have hated him in every school he has attended, and the generalization is then directly drawn from this that the boy then recognizes this means "the problem must lie primarily within him".

This linear and internal causal approach to the child's emotional problems failed to account for any interactional symptom etiology, any relational or interrelational support patterns for Bill's symptoms, and for the quid pro quo of compensatory family system behavior. Approaching the emotional problems of developmentally delayed children without using a systems frame of reference insures preoccupation with the "why?" of presenting problem behavior, further ensuring interference with exploration of the dysfunction itself, and continuing to support an irresponsible blaming position (Bowen, 1974).

Family psychotherapy was subsequently recommended for and elected by the B. family to aid in resolving old grief and anger issues (eventually a "funeral" was held during one of the treatment sessions for those parts of the past that family members were ready to allow to die).

Another element identified for treatment was the establishment of clear generational boundaries in this child-centered family to facilitate the children's and parents' individuation, but also to aid in the structural tasks of strengthening both the marital subsystem and the sibling subsystem.

All family members were to some degree exhibiting problems with self-concept. Since all had demonstrated a capacity for fairly open and direct communication, the family's prognosis for enhancing the self-worth of the individual members was promising.

The ensuing treatment (lasting approximately one year) utilized various elements of the whole system in varying family-member combinations. However, a child-focused, content-oriented perspective was avoided as the therapy assumed a second order orientation, looking always at the behavior in context.

Bill's symptoms, previously viewed as an "individual" problem, came to be seen partly as a protest against being "focused-on", and partly as serving a relational function for his mother; that of maintaining her ties with the past. Both Bill's disturbing behavior and John's compliant behavior aided the parents in the scapegoating of their elder son.

It is clear that treatment using the linear causal treatment approach of "modification of behavior" would not in fact have addressed the real etiology of the presenting symptom behaviors. "If we adopt the systems approach, we can no longer be satisfied by a 'psychiatric diagnosis' which perpetuates and crystalizes situations that are still capable of change. Instead, we need to explore the patient's interpersonal context as the primary means for developing adequate responses to symptomatic behavior" (Andolfi, 1976, p. 51).

CONCLUSION

The therapeutic process must work in a way that permits family members, including the identified patient, to give up their old assigned family roles and become self-treating.

Given the absence of a systemic relational context, gross miscommunication inevitably happens, and when the therapeutic process is "augmented" as well by drug therapy or even hospitalization, or is performed by a lone therapist in an individual situation with a single patient, families may be encouraged to entertain a punitive or peripheral perspective toward the child-patient whose intolerable behavior continues to overwhelm them and threaten their functions (Andolfi, 1979). The therapist may even join the family in a scapegoating stance, or, reciprocally, assume a protective role toward the patient. Andolfi (1979) has written, when the therapist accepts the family's diagnosis and focuses upon it, he is in danger of assuming the same "sickening" feelings which have consumed the family members as well as the identified patient.

Treatment intervention will not be effective if it reinforces the system dysfunction, that of a child-centered problem. Further, the less effective the treatment process, the more entrenched the family will become in its demands for a "solution" to the problem (Barragan, 1976). "The intervention becomes a medical deception, masking one of the biggest mystifications in psychiatry: the claim that an external agent can produce what

the patient, his family, and the larger community have failed to produce..." (Andolfi, 1979, p. 55).

When we view children's psychiatric problems from a different perspective, we are able to facilitate the resolution of seemingly impossible situations by helping individual patients to extricate themselves from their assigned role as family problem scapegoat, and other family members from their reciprocal parts as monitors of the child's role. Thus, the difficulty is no longer viewed as an individual emotional problem but as a relational, mutually supporting system of repetitive interactive patterns. The meaning the family has assigned to the problem is thus changed (Bowen, 1974; Andolfi, 1976).

These process dilemmas will not soon be resolved, but moral obligation requires us to continue to concern ourselves with the possible consequences to our patients of assigning extemporaneous ethics, as well as the implications such assignments have for the decision-making process itself. Those of us who work in the interdisciplinary world owe it to our colleagues and the children we serve to continue to be theoretically appropriate, relevant and accurate with our professional contributions, but above all we need to be current.

Bibliography

Adler, M. and C. Van Doren (Eds.). Great Treasury of Western Thought. New York: R.R. Bowker, 1977.

Andolfi, Maurizio. Family Therapy. New York: Plenum Press, 1979.

Barragan, Mariano. "The Child-Centered Family." In P. Guerin, Jr., (Ed.). Family Therapy Theory and Practice. New York: Gardner Press, 1974.

Bowen, Murray. "Alcoholism as Viewed Through Family Systems Theory and Family Psychotherapy." in New York Annals of Academy of Sciences, V. 233, 1974.

Davey, K.B. "A Model for Performance Analysis of an Ongoing Educational/Habilitative Interdisciplinary Team." Thesis presented to Department of Special Education and faculty of the Graduate College University of Nebraska, 1981. (unpublished)

Parker, Tommie and Cooper, Robert. "A Systems Approach to Treating the Family with a Mentally Retarded Child: Clinical Practice Related to Facilitating Effective Family and Family/Professional Relationships." Presented at Sixth International Congress of the International Association for the Scientific Study of Mental Retardation, Toronto, 1982 (unpublished manuscript).

Pearson, Paul H. "The Interdisciplinary Team Process or the Professional's Tower of Babel." Developmental Medicine and Child Neurology. (accepted for publication)

Weber, Gwen and Parker, Tommie. "A Comprehensive Study of Family and Professional Views of the Factors Affecting Positive Family Adaptation to a Disabled Child." in N. Stinnett, et al, (Eds.), Building Family Strengths 3, Lincoln, Nebraska: University of Nebraska Press, 1981.